State of Idaho Retiree Medical Plan Enrollment Application

Blue Cross of Idaho

If you have questions, contact:
Department of Administration
Office of Group Insurance
208-332-1860 or 1-800-531-0597
ogi@adm.idaho.gov

Date of Application _____
Date of Retirement _____
Date Active Employee Coverage Ends _____
Retiree Plan Effective Date _____
(subject to BCI approval)

Group Number: **10040000**

Please complete *each* section on the front and back page of this application in ink.

POLICY TYPE (please check one):

❑ **High Deductible** ❑ **PPO** ❑ **Traditional**

Applicant Information (Retiree) (You must be under age 65)

Your Name *(first, initial, last)*	Blue Cross ID Number *(if currently enrolled)*	Social Security Number	Date of Birth	❑ Male ❑ Female
		/ /	/ /	

Mailing Address	City, State, Zip Code	Phone Number
		( )

Marital Status: ❑ Single ❑ Married Common Law: ❑ Yes ❑ No Date of Marriage: _____	State **Agency** or department from which you are retired

Initial Hire Date	Amount of monthly retirement benefits	Credited state service hours on last day worked

Eligible Dependents for Whom Coverage is Being Elected

Name	Relationship	Birthdate	Social Security Number

Prior Coverage Information (Please complete for proper crediting of waiting periods.)

Has any person listed on this application been covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application? ❑ Yes ❑ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy Start Date (mm/dd/yy)	Date of Policy End Date (mm/dd/yy)
Retiree					
Spouse					
Child					
Child					
Child					

- If you have had other coverage with another carrier within 63 days of this request, please attach a copy of your Certificate of Health Coverage (HIPAA); this will ensure proper credit for any preexisting conditions, if applicable.
- If your coverage is terminated, please state reason: _____

Current Coverage Information (Please complete for proper coordination of benefits administration.)

Is any person listed on this application now covered by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy? ❑ Yes ❑ No If **YES**, please complete all information below for **each** person listed on this application.

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Start Date of Policy (mm/dd/yy)	Will Current Policy Continue?*
Retiree					❑ Yes ❑ No
Spouse					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No
Child					❑ Yes ❑ No

If any person listed on this application is covered by Medicare, please complete the following:

Name _____ Medicare Beneficiary Number _____ Reason for Medicare Entitlement (age, disability of ESRD) _____

Date of Medicare Entitlement: Part A ___/___/___ (mm dd yy) Part B ___/___/___ (mm dd yy)

*If your current coverage will remain active, please indicate if coverage is for: ❑ Medical ❑ Dental ❑ Vision

*If your current coverage will be terminated, please indicate termination date: ___/___/___ (mm dd yy)

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		
10040000										

White – Office of Group Insurance **White –** Office of Group Insurance **Pink –** Retiree

Auditor _____

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of the insurer, or my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com***.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition. **(Please see the next bullet down regarding credit given for qualifying previous coverage, "Creditable Coverage.")**

A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.

- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

APPLICATION MUST BE SIGNED AND DATED

Signature_____

Date_____

RETURN COMPLETED APPLICATION TO OFFICE OF GROUP INSURANCE
P.O. BOX 83720 BOISE, ID 83720-0035